		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0044594

Facility Name: SOUTHWEST SUBURBAN HEALTHCARE

Address: 10602 SOUTHWEST HIGHWAY (Number) CHICAGO RIDGE (City) 60415 (Zip Code)

County: COOK

Telephone Number: (847) 647-1717 **Fax #** (847) 647-0222

IDPA ID Number: 36-4303163

Date of Initial License for Current Owners: 11/01/99

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2001 to 12/31/2001 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) SHERWIN I. RAY
(Title) MANAGER

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number SOUTHWEST SUBURBAN HEALTHCARE # 0044594 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	231	Skilled (SNF)	231	84,315	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	231	TOTALS	231	84,315	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			2,668	2,668	8
9	SNF/PED					9
10	ICF	47,092	6,431	323	53,846	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	47,092	6,431	2,991	56,514	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 67.03%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 11/01/99

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 11/01/99 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 38 and days of care provided 2,668

Medicare Intermediary ADMINISTAR

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number SOUTHWEST SUBURBAN HEALTHCARI # 0044594 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	207,219	23,517	11,475	242,211		242,211	1,292	243,503			1
2	Food Purchase		224,441		224,441	(13,688)	210,753	(870)	209,883			2
3	Housekeeping	126,730	35,720	0	162,450		162,450	0	162,450			3
4	Laundry	110,148	15,414	0	125,562		125,562	0	125,562			4
5	Heat and Other Utilities			154,454	154,454		154,454	525	154,979			5
6	Maintenance	42,621	45,402	48,159	136,182		136,182	18,923	155,105			6
7	Other (specify):*			9,341	9,341		9,341	0	9,341			7
8	**TOTAL General Services**	486,718	344,494	223,429	1,054,641	(13,688)	1,040,953	19,870	1,060,823			8
	B. Health Care and Programs											
9	Medical Director	0		0	0		0	0	0			9
10	Nursing and Medical Records	1,935,963	85,621	18,713	2,040,297		2,040,297	23,323	2,063,620			10
10a	Therapy	122,169	44,088	42,412	208,669		208,669	8,335	217,004			10a
11	Activities	57,996	2,537	1,620	62,153		62,153	0	62,153			11
12	Social Services	67,483		4,228	71,711		71,711	0	71,711			12
13	Nurse Aide Training			0	0		0	0	0			13
14	Program Transportation			75	75		75	0	75			14
15	Other (specify):*				0		0	0	0			15
16	**TOTAL Health Care and Programs**	2,183,611	132,246	67,048	2,382,905	0	2,382,905	31,658	2,414,563			16
	C. General Administration											
17	Administrative	90,188		44,635	134,823		134,823	32,689	167,512			17
18	Directors Fees			0	0		0	0	0			18
19	Professional Services			209,345	209,345		209,345	(176,887)	32,458			19
20	Dues, Fees, Subscriptions & Promotions			42,934	42,934		42,934	(13,048)	29,886			20
21	Clerical & General Office Expenses	136,660	15,770	165,691	318,121		318,121	(55,532)	262,589			21
22	Employee Benefits & Payroll Taxes			431,303	431,303	13,688	444,991	0	444,991			22
23	Inservice Training & Education			810	810		810	454	1,264			23
24	Travel and Seminar			329	329		329	479	808			24
25	Other Admin. Staff Transportation			4,101	4,101		4,101	2,181	6,282			25
26	Insurance-Prop.Liab.Malpractice			164,477	164,477		164,477	4,233	168,710			26
27	Other (specify):*			0	0		0	38,361	38,361			27
28	**TOTAL General Administration**	226,848	15,770	1,063,625	1,306,243	13,688	1,319,931	(167,070)	1,152,861			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,897,177	492,510	1,354,102	4,743,789	0	4,743,789	(115,542)	4,628,247			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number SOUTHWEST SUBURBAN HEALTHCARE #0044594 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			9,431	9,431		9,431	3,927	13,358			30
31	Amortization of Pre-Op. & Org.				0		0	0	0			31
32	Interest			178,991	178,991		178,991	15,898	194,889			32
33	Real Estate Taxes			354,587	354,587		354,587	0	354,587			33
34	Rent-Facility & Grounds			1,070,912	1,070,912		1,070,912	6,149	1,077,061			34
35	Rent-Equipment & Vehicles			35,078	35,078		35,078	(8,244)	26,834			35
36	Other (specify):*				0		0	0	0			36
37	TOTAL Ownership			1,648,999	1,648,999	0	1,648,999	17,730	1,666,729			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers		62,355	76,848	139,203		139,203	(13,787)	125,416			39
40	Barber and Beauty Shops				0		0	0	0			40
41	Coffee and Gift Shops				0		0	0	0			41
42	Provider Participation Fee			137,215	137,215		137,215	0	137,215			42
43	Other (specify):*				0		0	0	0			43
44	TOTAL Special Cost Centers	0	62,355	214,063	276,418	0	276,418	(13,787)	262,631			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,897,177	554,865	3,217,164	6,669,206	0	6,669,206	(111,599)	6,557,607			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

Facility Name & ID Number SOUTHWEST SUBURBAN HEALTHCARE # 0044594 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(5,806)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(870)	2		13
14	Non-Care Related Interest	(329)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(256)	20		17
18	Fines and Penalties	(15,593)	21		18
19	Entertainment				19
20	Contributions	(1,391)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(14,857)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(687)	20		28
29	Other-Attach Schedule SEE PAGE 5A	0			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (39,789)		$ 0	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(71,810)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (71,810)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (111,599)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

SOUTHWEST SUBURBAN HEALTHCARE

ID# 0044594

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number SOUTHWEST SUBURBAN HEALTHCARE # 0044594 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	1,292	0	0	0	0	0	0	0	0	0	1,292	1
2	Food Purchase	(870)	0	0	0	0	0	0	0	0	0	0	(870)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	525	0	0	0	0	0	0	0	0	0	525	5
6	Maintenance	0	10,205	0	8,718	0	0	0	0	0	0	0	18,923	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(870)	12,022	0	8,718	0	0	0	0	0	0	0	19,870	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	23,323	0	0	0	0	0	0	0	0	0	23,323	10
10a	Therapy	0	9,214	(879)	0	0	0	0	0	0	0	0	8,335	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	32,537	(879)	0	0	0	0	0	0	0	0	31,658	16
	C. General Administration													
17	Administrative	0	47,903	0	(15,214)	0	0	0	0	0	0	0	32,689	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(176,915)	0	28	0	0	0	0	0	0	0	(176,887)	19
20	Fees, Subscriptions & Promotions	(17,191)	0	4,143	0	0	0	0	0	0	0	0	(13,048)	20
21	Clerical & General Office Expenses	(15,593)	(115,500)	71,435	4,126	0	0	0	0	0	0	0	(55,532)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	454	0	0	0	0	0	0	0	0	454	23
24	Travel and Seminar	0	0	479	0	0	0	0	0	0	0	0	479	24
25	Other Admin. Staff Transportation	0	0	2,181	0	0	0	0	0	0	0	0	2,181	25
26	Insurance-Prop.Liab.Malpractice	0	0	4,233	0	0	0	0	0	0	0	0	4,233	26
27	Other (specify):*	0	0	36,021	2,340	0	0	0	0	0	0	0	38,361	27
28	**TOTAL General Administration**	(32,784)	(244,512)	118,946	(8,720)	0	0	0	0	0	0	0	(167,070)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(33,654)	(199,953)	118,067	(2)	0	0	0	0	0	0	0	(115,542)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number SOUTHWEST SUBURBAN HEALTHCARE # 0044594 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(5,806)	0	9,733	0	0	0	0	0	0	0	0	3,927	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(329)	0	16,227	0	0	0	0	0	0	0	0	15,898	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	6,149	0	0	0	0	0	0	0	0	6,149	34
35	Rent-Equipment & Vehicles	0	(14,787)	6,543	0	0	0	0	0	0	0	0	(8,244)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(6,135)	(14,787)	38,652	0	0	0	0	0	0	0	0	17,730	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	(13,787)	0	0	0	0	0	0	0	0	(13,787)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	(13,787)	0	0	0	0	0	0	0	0	(13,787)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(39,789)	(214,740)	142,932	(2)	0	0	0	0	0	0	0	(111,599)	45

Facility Name & ID Number SOUTHWEST SUBURBAN HEALTHCARE # 0044594 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		BALMORAL HOME INC	CHICAGO, IL			
		EMERALD PARK NURSING CENTER	EVERGREEN PARK, I	CAREPLUS MGMT	NILES	MGMT/CLERICAL
		CENTRAL HOME INC	CHICAGO, IL	CAREPLUS REHABILITATIVE SERVICES		
		RREM INC d/b/a WINSTON MANOR NURSING HO	CHICAGO, IL		NILES	THERAPY
		SOVEREIGN HEALTH CARE LLC	CHICAGO, IL	NIVRAM MGMT	CHICAGO	MGMT
SEE ATTACHED SCHEDULES FOR OWNERS SOUTHWEST SUBURBAN 1/1/01-10/31/01 & CHICAGO RIDGE 11/1/01-12/31/01						
CAREPLUS MGMT/CAREPLUS REHAB FOR PERIOD 1/1/01-10/31/01 / NIVRAM MGMT FOR PERIOD 11/1/01-12/31/01						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	35	COMPUTER LEASE	$ 14,787	CAREPLUS MGMT INC		$	$ (14,787)	1
2	V	19	ADMIN. CONSULTANT FEES	170,000	" "			(170,000)	2
3	V	19	DATA PROCESSING FEES	12,000	" "			(12,000)	3
4	V	21	CLERICAL FEES	115,500	" "			(115,500)	4
5	V	1	DIETARY CONSULTANT FEES	6,500	" "			(6,500)	5
6	V	1	DIETARY SALARIES		" "		7,792	7,792	6
7	V	5	ELECTRICITY		" "		525	525	7
8	V	6	REPAIRS		" "		299	299	8
9	V	6	MAINTENANCE SALARIES		" "		9,906	9,906	9
10	V	10	NURSING		" "		23,323	23,323	10
11	V	10a	THERAPY SALARIES		" "		9,214	9,214	11
12	V	17	ADMIN SALARIES		" "		47,903	47,903	12
13	V	19	PROFESSIONAL FEES		" "		5,085	5,085	13
14	Total			$ 318,787			$ 104,047	$ * (214,740)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SOUTHWEST SUBURBAN HEALTHCARE # 0044594 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	20	DUES/LICENSES/WANT ADS	$	CAREPLUS MGMT INC		$ 4,143	$ 4,143	15
16	V	21	OFFICE SALARIES/EXPENSES		" "		71,435	71,435	16
17	V	23	SEMINARS		" "		454	454	17
18	V	24	TRAVEL		" "		479	479	18
19	V	25	TRANSPORTATION		" "		2,181	2,181	19
20	V	26	INSURANCE		" "		4,233	4,233	20
21	V	27	EMPLOYEE BENEFITS		" "		36,021	36,021	21
22	V	30	SL DEPRECIATION		" "		9,733	9,733	22
23	V	32	INTEREST		" "		16,227	16,227	23
24	V	34	OFFICE RENT		" "		6,149	6,149	24
25	V	35	EQUIP RENT/AUTO LEASE		" "		6,543	6,543	25
26	V								26
27	V								27
28	V								28
29	V	10a	THERAPY SERVICES	42,844	CAREPLUS REHABILITATIVE SERVICES		41,965	(879)	29
30	V	39	ANCILLARY THERAPY	75,996	" "		62,209	(13,787)	30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 118,840			$ 261,772	$ * 142,932	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SOUTHWEST SUBURBAN HEALTHCARE # 0044594 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17		$ 44,635	NIVRAM MGMT INC		$	$ (44,635)	15
16	V	6	MAINTENANCE SALARIES		" "		8,718	8,718	16
17	V	19	ACCOUNTING FEES		" "		28	28	17
18	V	21	OFFICE EXPENSES		" "		393	393	18
19	V	27	PAYROLL TAXES		" "		2,340	2,340	19
20	V	17	ADMINISTRATOR SALARIES		" "		4,800	4,800	20
21	V	17	ASST ADMIN SALARIES		" "		15,779	15,779	21
22	V	17	ADMINISTRATIVE SALARIES		" "		8,842	8,842	22
23	V	21	CLERICAL SALARIES		" "		3,733	3,733	23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 44,635			$ 44,633	$ * (2)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SOUTHWEST SUBURBAN HEALTHCAR # 0044594 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	CAREPLUS MGMT ALLOCATIONS:		OWNERSHIP INTEREST IS FOR PERIOD 1/1/01-10/31/01						$		1
2	SHERWIN RAY	PRESIDENT	ADMIN/FINANCI	50.00	SEE ATTACHED	4.7	7.76	SALARY	14,351	17-7	2
3	JAKOB BAKST	DIR OPERAT'NS	ADMIN/CONS.	50.00	SCHEDULES	4.7	7.76	" "	14,351	17-7	3
4											4
5											5
6	NIVRAM MGMT ALLOCATIONS:		OWNERSHIP INTEREST IS FOR PERIOD 11/1/01-12/31/01								6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 28,702		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number SOUTHWEST SUBURBAN HEALTHCARE # 0044594 Report Period Beginning: 01/01/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CAREPLUS MANAGEMENT INC
Street Address: 5940 W TOUHY
City / State / Zip Code: NILES 60714
Phone Number: (847) 647-1717
Fax Number: (847) 647-0222

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY SALARIES	CENSUS DAYS	506,586	11 HOMES	$ 83,890	$ 83,890	47,059	$ 7,792	1
2	5	ELECTRICITY	" "	606,625	15 HOMES	6,767		47,059	525	2
3	6	REPAIRS	" "	606,625	15 HOMES	3,858		47,059	299	3
4	6	MAINTENANCE SALARIES	" "	606,625	15 HOMES	127,691	127,691	47,059	9,906	4
5	10	NURSING	" "	606,625	15 HOMES	300,646	300,646	47,059	23,323	5
6	10a	THERAPY SALARIES	" "	570,238	13 HOMES	111,658	96,375	47,059	9,214	6
7	17	ADMIN SALARIES	" "	606,625	15 HOMES	617,499	617,499	47,059	47,903	7
8	19	PROFESSIONAL FEES	" "	606,625	15 HOMES	65,550		47,059	5,085	8
9	20	DUES/LICENSES/WANT ADS	" "	606,625	15 HOMES	53,408		47,059	4,143	9
10	21	OFFICE SALARIES/EXPENSES	" "	606,625	15 HOMES	920,855	677,141	47,059	71,435	10
11	23	SEMINARS	" "	606,625	15 HOMES	5,849		47,059	454	11
12	24	TRAVEL	" "	606,625	15 HOMES	6,170		47,059	479	12
13	25	TRANSPORTATION	" "	606,625	15 HOMES	28,114		47,059	2,181	13
14	26	INSURANCE	" "	606,625	15 HOMES	54,564		47,059	4,233	14
15	27	EMPLOYEE BENEFITS	" "	606,625	15 HOMES	464,335		47,059	36,021	15
16	30	SL DEPRECIATION	" "	606,625	15 HOMES	125,471		47,059	9,733	16
17	32	INTEREST	" "	606,625	15 HOMES	209,175		47,059	16,227	17
18	34	OFFICE RENT	" "	606,625	15 HOMES	79,265		47,059	6,149	18
19	35	EQUIP RENT/AUTO LEASE	" "	606,625	15 HOMES	84,343		47,059	6,543	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,349,108	$ 1,903,242		$ 261,645	25

Facility Name & ID Number SOUTHWEST SUBURBAN HEALTHCARE # 0044594 Report Period Beginning: 01/01/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: NIVRAM MGMT INC
Street Address: 2155 W. PIERCE
City / State / Zip Code: CHICAGO, IL 60622
Phone Number: (773) 252-3208
Fax Number: (773) 252-3688

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	21	BANK CHARGES	RESIDENT BEDS	980	6	$ 485	$	38	$ 19	1
2	21	OFFICE EXPENSES	" "	980	6	851		38	33	2
3	21	SUPPLIES	" "	980	6	6,194		38	240	3
4	21	TELEPHONE	" "	980	6	2,615		38	101	4
5	19	ACCOUNTING FEES	" "	980	6	713		38	28	5
6	27	PAYROLL TAXES	" "	980	6	60,345		38	2,340	6
7	17	D.MURTHY, ADMIN							4,800	7
8	17	D.GARCIA, ASST ADMIN							8,173	8
9	17	M.MERMELSTEIN, ASST ADMIN			SEE SCHEDULES				7,606	9
10	17	H.MERMELSTEIN,ADMIN'TIVE			" "				8,842	10
11	21	D.MERMELSTEIN, CLERICAL			" "				3,733	11
12	6	M.MERMELSTEIN, MAINT			" "				2,022	12
13	6	OTHER MAINT. SALARIES							6,696	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 71,203	$		$ 44,633	25

Facility Name & ID Number SOUTHWEST SUBURBAN HEALTHCARE # 0044594 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	CAREPLUS MANAGEMENT ALLOCATION: LOC, ETC						$	$			$ 16,227	1
2												2
3	CAREPLUS MGMT - CIB BK	X		CAPL IMPR LOAN FEES	5 YR AMORT	2/23/01	1,575	0	3/23/06		263	3
4	CAREPLUS MGMT - CIB BK	X		CAPITAL IMPROVEMENT	$6,635.09	2/23/01	315,000	0	3/23/06	PRIME+	20,392	4
5	ERIC ROTHNER		X				577,500	0			11,029	5
	Working Capital											
6	CAREPLUS MGMT INC	X		WORKING CAPITAL	DEMAND	Nov-99	205,000	0		PRIME+	146,503	6
7	PARKWAY BANK		X	LINE OF CREDIT	DEMAND	11/01	104,000	382,000		PRIME+	475	7
8												8
9	TOTAL Facility Related				$6,635.09		$ 1,203,075	$ 382,000			$ 194,889	9
	B. Non-Facility Related*											
10	IDES		X	LATE FEES							329	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$ 0	$ 0			$ 329	14
15	TOTALS (line 9+line14)						$ 1,203,075	$ 382,000			$ 195,218	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number SOUTHWEST SUBURBAN HEALTHCARE # 0044594 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 335,030	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 344,809	2
3. Under or (over) accrual (line 2 minus line 1).		$ 9,779	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 344,808	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 354,587	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	313,799	8
	1997	325,819	9
	1998	325,903	10
	1999	331,718	11
	2000	344,809	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2000 TAX BILL.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible]

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME SOUTHWEST SUBURBAN HEALTHCARE COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0044594

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200(

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	24-18-101-025-0000	NURSING HOME	$ 252,838.12	$ 252,838.12
2.	24-18-101-039-0000	NURSING HOME	$ 91,971.07	$ 91,971.07
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 344,809.19	$ 344,809.19

B. **Real Estate Tax Cost Allocation**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services' ____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill whic is normally paid during 2001.

Facility Name & ID Number SOUTHWEST SUBURBAN HEALTHCARE # 0044594 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 87,480 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 3+BASEMENT

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME	73,980		$	1
2					2
3	TOTALS	73,980		$ 0	3

Facility Name & ID Number SOUTHWEST SUBURBAN HEALTHCARE # 0044594 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	HANDRAILS / FLOORING / SIGN / ELECTRICAL REPAIR			2000	23,656	681	27.5	681		1,330	9
10	ELEVATOR REPAIR / COMPRESSOR			2001	22,890	109	27.5	109		109	10
11	SIGN			2001	1,419	5	39	5		5	11
12	PLUMBING / BOILER			2001	12,092		39	13	13	13	12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34	RELATED PARTY ALLOCATION - CAREPLUS MGMT					91		91			34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number SOUTHWEST SUBURBAN HEALTHCARE # 0044594 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 60,057	$ 886		$ 899	$ 13	$ 1,457	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SOUTHWEST SUBURBAN HEALTHCARE # 0044594 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 46,360	$ 5,713	$ 1,820	$ (3,893)	8-15 YRS	$ 3,639	71
72	Current Year Purchases	43,535	2,923	997	(1,926)	10-15 YRS	997	72
73	Fully Depreciated Assets				0			73
74	** RELATED PARTY - ALLOCATED SL DEPN: CAREPLUS MGMT, 9,642		9,642	9,642	0			74
75	TOTALS	$ 89,895	$ 18,278	$ 12,459	$ (5,819)		$ 4,636	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$ 0		$	76
77							0			77
78							0			78
79							0			79
80	TOTALS			$ 0	$ 0	$ 0	$ 0		$ 0	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 149,952	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 19,164	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 13,358	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (5,806)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 6,093	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number SOUTHWEST SUBURBAN HEALTHCARE # 0044594 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: FAIRHAVEN OF CHICAGO RIDGE

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		231	11/01/99	$ 1,070,912			3
4	Additions							4
5								5
6								6
7	TOTAL		231		$ 1,070,912 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [X] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning 11/01/99
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	12/31/2002	$
13.	12/31/2003	$
14.	12/31/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO

16. Rental Amount for movable equipment: $ 28,723 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	FACILITY VAN		$ 679.69	$ 6,355	17
18					18
19					19
20					20
21	TOTAL		$ 679.69	$ 6,355	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number SOUTHWEST SUBURBAN HEALTHCARE # 0044594 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$ 0
2	Books and Supplies				0
3	Classroom Wages (a)				0
4	Clinical Wages (b)				0
5	In-House Trainer Wages (c)				0
6	Transportation				0
7	Contractual Payments				0
8	Nurse Aide Competency Tests				0
9	TOTALS	$ 0	$ 0	$ 0	$ 0
10	SUM OF line 9, col. 1 and 2 (e)	$ 0			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number SOUTHWEST SUBURBAN HEALTHCARE # 0044594 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 23,338	$		$ 23,338	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			729			729	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			51,931			51,931	4
5	Physician Care		visits							5
6	Dental Care	39-3	visits			850			850	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				48,868		48,868	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	MED.SUPPLIES/RENTALS Other (specify):	39-2					13,487		13,487	13
14	TOTAL			$		$ 76,848	$ 62,355		$ 139,203	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number SOUTHWEST SUBURBAN HEALTHCARE **#** 0044594 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2001 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	709,417		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	62,012		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): R.E.TAX ESCROW			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 771,429	$ 0	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	13,511		15
16	Equipment, at Historical Cost	26,273		16
17	Accumulated Depreciation (book methods)	(462)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 39,322	$ 0	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 810,751	$ 0	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 170,564	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	8,229		28
29	Short-Term Notes Payable	382,000		29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 560,793	$ 0	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 0	$ 0	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 560,793	$ 0	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 249,958	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 810,751	$ 0	48

***(See instructions.)**

Facility Name & ID Number SOUTHWEST SUBURBAN HEALTHCARE # 0044594 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,121,138)	1
2	Restatements (describe):		2
3	POST-CLOSING ADJUSTMENTS (SEE ATTACHED)	(109,506)	3
4	ROUNDING	1	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,230,643)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(662,205)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) ADJ FROM BALANCE SHEET OF SOUTHWEST		15
16	Other (describe) SUBURBAN TO CHICAGO RIDGE	2,142,806	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 1,480,601	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 0	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 249,958	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number SOUTHWEST SUBURBAN HEALTHCARE # 0044594 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,095,530	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,095,530	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen	16,661	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 16,661	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 0	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 0	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	VENDING COMMISSIONS	400	28
28a	OTHER INCOME	8	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 408	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,112,599	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,054,641	31
32	Health Care	2,382,905	32
33	General Administration	1,306,243	33
	B. Capital Expense		
34	Ownership	1,648,999	34
	C. Ancillary Expense		
35	Special Cost Centers	139,203	35
36	Provider Participation Fee	137,215	36
	D. Other Expenses (specify):		
37	OUT-OF-PERIOD EXPENSES	11,868	37
38	LOSS ON SALE OF ASSETS	93,730	38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,774,804	40
41	**Income before Income Taxes (line 30 minus line 40)****	(662,205)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (662,205)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.**
TAX RETURN IS PREPARED ON CASH BASIS.

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number SOUTHWEST SUBURBAN HEALTHCARE # 0044594 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,210	2,493	$ 72,752	$ 29.18	1
2	Assistant Director of Nursing	1,386	1,436	36,508	25.42	2
3	Registered Nurses	26,129	27,955	611,845	21.89	3
4	Licensed Practical Nurses	16,415	18,018	334,108	18.54	4
5	Nurse Aides & Orderlies	76,926	84,001	806,369	9.60	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,316	6,699	122,169	18.24	8
9	Activity Director	723	812	6,800	8.37	9
10	Activity Assistants	5,573	6,005	51,196	8.53	10
11	Social Service Workers	5,372	5,649	67,483	11.95	11
12	Dietician					12
13	Food Service Supervisor	2,147	2,222	30,257	13.62	13
14	Head Cook	4,798	5,179	47,799	9.23	14
15	Cook Helpers/Assistants	14,052	15,177	129,163	8.51	15
16	Dishwashers					16
17	Maintenance Workers	3,544	3,711	42,621	11.49	17
18	Housekeepers	17,574	18,093	126,730	7.00	18
19	Laundry	12,371	13,783	110,148	7.99	19
20	Administrator	2,506	2,748	56,451	20.54	20
21	Assistant Administrator	1,644	1,820	33,737	18.54	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,564	13,150	136,660	10.39	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	4,133	4,365	74,381	17.04	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	216,383	233,316	$ 2,897,177 *	$ 12.42	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 8,333	1-3	35
36	Medical Director	O	0	9-3	36
37	Medical Records Consultant	N	3,528	10-3	37
38	Nurse Consultant	T	6,200	10-3	38
39	Pharmacist Consultant	H	8,985	10-3	39
40	Physical Therapy Consultant	L	6,000	10a-3	40
41	Occupational Therapy Consultant	Y	6,000	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	1,620	11-3	44
45	Social Service Consultant	E	3,796	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 44,462		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number SOUTHWEST SUBURBAN HEALTHCARE # 0044594 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
SUE BASSED	ADMIN	0	$ 56,451
DARLENE GUZY	ASST ADMIN	0	24,610
MARTHA RIOS	ASST ADMIN	0	9,127
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 90,188

B. Administrative - Other

Description		Amount
NIVRAM MGMT INC	MANAGEMENT FEES	$ 44,635
TOTAL (agree to Schedule V, line 17, col. 3)		$ 44,635
(Attach a copy of any management service agreement)		

C. Professional Services

Vendor/Payee	Type	Amount
CAREPLUS MGMT	DATA PROC	$ 12,000
CAREPLUS MGMT	ADMIN CONSULT	170,000
IMPRINT ENTERPRISES	DATA PROC	508
AMERICAN DATA	DATA PROC	42
KBKB	ACCT	17,100
MEYER MAGENCE	LEGAL	1,225
CSC	LEGAL	265
RICHARD PEELO	M/C COST REPORT	4,125
PERSONNEL PLANNERS	UNEMPL CONSULT	1,832
KESSLER ORLEAN SILVER	ACCT	1,600
HDSI	DATA PROC	648
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 209,345

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 78,839
Unemployment Compensation Insurance	47,072
FICA Taxes	216,667
Employee Health Insurance	85,984
Employee Meals	13,688
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	930
EMPLOYEE PHYSICAL EXAMS	0
PENSION/PROFIT SHARING PLANS	1,811
CHICAGO HEAD TAX	0
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 444,991

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	19,641
Health Care Worker Background Check	0
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	15,544
TRUST FEES/CONTRIBUTIONS/ETC	1,647
MGMT CO ALLOCATION	4,143
DUES & SUBSCRIPTIONS	3,420
LICENSES & PERMITS	2,682
TRUST FEES/CONTRIBUTIONS/ETC	(1,647)
Less: Public Relations Expense	(0)
Non-allowable advertising	(14,857)
Yellow page advertising	(687)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 29,886

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
TRAVEL	329
MGMT CO ALLOCATION	479
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 808

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number SOUTHWEST SUBURBAN HEALTHCARE # 0044594 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number SOUTHWEST SUBURBAN HEALTHCARE # 0044594 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL COUNCIL LONG TERM CARE**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ _____ Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **137,215**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **13,688** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ _____

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ _____

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.

Facility Name & ID#: SOUTHWEST SUBURBAN HEALTHCARE #0044594 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	8,333	
	REPAIRS & MAINTENANCE		3,142	
			0	11,475
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		0	
			0	0
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		65,418	
	ELECTRICITY		66,686	
	WATER		20,993	
	CABLE TV - LOBBY		1,357	
			0	154,454
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		2,736	
	PAINTING & DECORATING		0	
	BUILDING REPAIRS		8,265	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		21,061	
	ELEVATOR MAINTENANCE & REPAIR		7,046	
	OUTSIDE LABOR		485	
	EXTERMINATING SERVICE		4,975	
	FIRE SERVICE		3,591	
			0	
			0	
			0	48,159
7	**OTHER**			
	SCAVENGER		9,177	
	SECURITY SERVICE		164	9,341
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	0	0

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTAN	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	3,528	
	PHARMACY CONSULTANT	XVIII B 39-2	8,985	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	6,200	
			0	
			0	18,713
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		12,825	
	SPEECH THERAPY SERVICES		2,619	
	OCCUPATIONAL THERAPY SERVICES		4,068	
	THERAPY CONTRACT SERVICES		10,900	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	6,000	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	6,000	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	42,412
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	1,620	
			0	1,620
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		432	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	3,796	
			0	4,228
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number SOUTHWEST SUBURBAN HEALTHCARE **#0044594** **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		75	75
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	44,635	44,635
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	16,279	
	ADMINISTRATIVE CONSULTANTS	XIX C	170,000	
	PROFESSIONAL FEES	XIX C	23,066	
			0	209,345
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	14,857	
	EMPLOYEE WANT ADS	XIX F	19,641	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	3,420	
	LICENSES & PERMITS	XIX F	2,682	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	687	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	256	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	1,391	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	0	42,934
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES		25	
	EQUIPMENT REPAIR & MAINTENANCE		6,889	
	OUTSIDE CLERICAL SERVICES		115,500	
	PENALTIES / OVERDRAFT CHARGES	VI 18	15,593	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		79	
	TELEPHONE		27,605	
	MESSENGER SERVICE		0	
			0	165,691

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	216,667	
	UNEMPLOYMENT COMPENSATION	XIX D	47,072	
	WORKERS COMPENSATION INSURANC	XIX D	78,839	
	HOSPITALIZATION INSURANCE	XIX D	85,984	
	EMPLOYEE BENEFITS - OTHER	XIX D	930	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	1,811	
	CHICAGO HEAD TAX	XIX D	0	431,303
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		810	810
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	329	
			0	
			0	329
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		4,101	4,101
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		164,477	164,477
27	**OTHER**			
	BAD DEBTS	VI 24	0	
			0	0

GRAND TOTAL COLUMN 3 OTHER 1,354,102

SOUTHWEST SUBURBAN HEALTHCARE
EMPLOYEE MEAL RECLASSIFICATION
12/31/2001

TOTAL FOOD PURCHASE	224,441
LESS SALES TAX	(870)
NET FOOD	225311
TOTAL PATIENT CENSUS	56,514
TIME 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	169542
ADD # EMPLOYEE MEALS/DAY	30
TIME # DAYS	365
TOTAL EMPLOYEE MEALS	10950

PATIENT MEALS	169542
ADD EMPLOYEE MEALS	10950
TOTAL MEALS/YEAR	180492
NET FOOD	225311
DIVIDE TOTAL MEALS/YEAR	180492
COST PER MEAL	1.25
TIME EMPLOYEE MEALS	10950
EMPLOYEE MEAL RECLASSIFICATION	13688